MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF JANUARY 24, 2011

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

THE PUBLIC HEALTH COUNCIL OF
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
Henry I. Bowditch Public Health Council Room, 2nd Floor
250 Washington Street, Boston, MA

Updated Docket: Monday, January 24, 2011, 9:00 AM

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1. ROUTINE ITEMS: No Floor Discussion

a. Compliance with Massachusetts General Laws, Chapter 30A, §11A ½ **(No Vote)**

b. Record of the Public Health Council Meeting of November 10, 2010 **(Approved)**

2. PROPOSED REGULATIONS: No Floor Discussion/Information Only (No Votes)

a. Informational Briefing on Proposed New Regulation 105 CMR 201.000: Head Injuries and Concussions in Extracurricular Athletics

b. Informational Briefing on Proposed Amendments to 105 CMR 532.000, to Add Section 532.300: Requirements for Use of Mobile Poultry Processing Unit

c. Informational Briefing on Proposed Amendments to 105 CMR 300.000: Updates to Requirements for Use of Electronic System for Disease Reporting

DETERMINATION OF NEED PROGRAM:

3. Compliance Memorandum:

Previously Approved Project Application No.3-3B62 of Lowell General Hospital – Request for a significant change to decrease the project's maximum capital expenditure and gross square footage and to build out approved shell space **(Approved)**

4. Category 1 Application:

Project Application No. 4-3B94 of Whittier Rehabilitation Hospital – Request for transfer of ownership of Metro West Rehab Corporation d/b/a Whittier Rehabilitation Hospital- Westborough, an 88-bed acute inpatient rehabilitation hospital to Whittier Healthcare Holdings II, Inc. **(Approved)**

The Commissioner and the Public Health Council are defined by law as constituting the Department of Public Health. The Council has one regular meeting per month. These meetings are open to public attendance except when the Council meets in Executive Session. The Council's meetings are not hearings, nor do members of the public have a right to speak or address the Council. The docket will indicate whether or not floor discussions are anticipated. For purposes of fairness since the regular meeting is not a hearing and is not advertised as such, presentations from the floor may require delaying a decision until a subsequent meeting.

PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council (M.G.L. c17, §§ 1, 3) was held on January 24, 2011, 9:10 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair, Mr. John Auerbach, Commissioner, Department of Public Health, Mr. Harold Cox, Dr. John Cunningham, Dr. Michèle David (arrived at 9:26 a.m.), Dr. Muriel Gillick, Mr. Paul Lanzikos, Mr. Josè Rafael Rivera, Dr. Meredith Rosenthal (arrived at 9:20 a.m.), Mr. Albert Sherman(arrived at 9:15 a.m.), and Dr. Alan Woodward. Absent members were: Ms. Helen Caulton-Harris, Mr. Denis Leary, Ms. Lucilia Prates Ramos, Dr. Michael Wong and Dr. Barry Zuckerman.

Chair Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. He summarized the agenda of the day and noted that there were seven members present at the meeting at the moment so the Council will hear informational items until a quorum of eight is present.

PROPOSED REGULATIONS: NO FLOOR DISCUSSION/INFORMATION ONLY: INFORMATIONAL BRIEFING ON PROPOSED NEW REGULATION 105 CMR 201.000: HEAD INJURIES AND CONCUSSIONS IN EXTRACURRICULAR ATHLETICS

Note: For the record, during Dr. Smith's presentation, Mr. Albert Sherman arrived at 9:15 a.m. securing a quorum of eight members present. Dr. Meredith Rosenthal followed, arriving at 9:20 a.m. and then Dr. Michèle David arrived at 9:26 a.m., resulting in ten members present.

Dr. Lauren Smith, Medical Director, Department of Public Health

presented an Informational Briefing on Proposed New Regulation 105 CMR 201.000: Head Injuries and Concussions in Extracurricular Athletics. Some excerpts from her presentation follow.

"…In the United States, over 135,000 kids, age five to eight, are treated for sports and recreation-related traumatic brain injuries, annually. In Massachusetts, 18% of middle and high school students who were interviewed as part of the Youth Health Survey indicated that they have had a head injury that has been serious enough to cause the kinds of symptoms that are consistent with a concussion, including blurry vision, headache, and memory problems. That is in the past twelve months. The Massachusetts Interscholastic Athletic Association reports that there are about 200,000 students that are engaged in interscholastic sports – that is about 36,000 thousand sports-related head injuries per year…"

"Concussion can cause a wide variety of functional short and long term changes, including problems with thinking, sensation, language, and emotion….and some emotional indications not traditionally associated with concussion such as anxiety, depression, and changes in personality…Athletes who have one concussion are at increased risk for having another one and children and teens are more likely to suffer concussion and take longer to recover than adults…There is a phenomenon called a second impact syndrome which is rare but potentially lethal, where a subsequent head injury occurs before the healing of the prior one, and can cause death…"

It was noted that in July of 2010, Governor Patrick signed into law An Act Relative to Safety Regulations for School Athletic Programs, which went into effect as an emergency provision. Two sets of guidance documents have been issued by DPH to help schools comply with the law while the regulations are in development. The regulations require the Department of Public Health to establish an annual training program for key staff involved in sports for youth including athletic directors, coaches, trainers, parents, students, school nurses and school physicians who work with athletic teams. The legislation further requires that athletes who are suspected of having concussions must be removed from play until written

clearance has been provided by a licensed health care professional. "This will require a culture shift - a student can no longer shake off a suspected concussion and go back into play," said Dr. Smith.

Dr. Smith noted that in order to develop the regulations, DPH convened an internal DPH staff work group including the Essential School Health, School Based Health Centers, and Injury Prevention and Control Programs and further convened an expert clinical advisory group of leaders in the field. Staff continues to work with key stakeholders including the Massachusetts Medical Society, Athletic Trainers of Massachusetts (ATOM), the Massachusetts Interscholastic Athletic Association (MIAA), Children's Hospital, Massachusetts General Hospital, American Academy of Pediatrics, Sports Legacy Institute and the Department of Elementary and Secondary Education (DESE).

Dr. Smith noted the key provisions of the regulations. The regulations apply to all extracurricular interscholastic sports for all public middle, and high schools and all MIAA member schools. However, the regulations to not apply to town sports such as Little League and Pop Warner teams. The regulations address six areas: 1. school policies and procedures, 2. training, 3. training participation requirements for students and parents, 4. exclusion from play, 5. medical clearance and return to play policies, and 6. record maintenance/ reporting requirements. She further noted that all school districts and schools must have policies and procedures governing the prevention and management of sports-related head injuries and these must include: a person responsible for development/ implementation, training requirements, documentation of head injury history of students, protocols in place for managing sports-related head injuries or suspected concussions, protocols for graduated re-entry plans for students, instructions to discourage dangerous play and teach techniques that minimize head injury and penalties for failure to comply with these policies.

Dr. Smith noted that DPH annual sports-related head injury training is required of coaches, athletic directors, certified athletic trainers, volunteers, school physicians and school nurses, referees and

umpires who are school employees, marching band directors, parents of students in extracurricular athletics and the students participating in extracurricular athletics. There are two free, on-line trainings available, one is by the National Federation for High School Sports (NFHS) and the other is "Heads Up Concussion" by the federal Centers for Disease Control (CDC). These trainings must be completed by the parents and students before the student may participate in the extracurricular activity. Verification of the training and receipt of materials is required by schools. The CDC training is available in Spanish and hopefully in other languages soon. For those parents without access to a computer DPH has printed materials available that the schools can make available and have the parent attest that they read and understand the materials.

Students need to complete and submit a pre-participation form that will provide a comprehensive history of any head injuries prior to participation. Students should inform the school of head injuries that have occurred outside of school. If injured during the season, a "Report of Head Injury During Sports Season Form" needs to be completed and submitted, and a "Medical Clearance and Authorization Form" is required to return to the extracurricular athletic activity with a graduated re-entry plan in place.

Licensed health professionals providing medical authorization for return to play must document completion of specific training in concussion assessment and management by September 2013. Parents must be notified promptly of any head injury or suspected concussion. Schools must report to DPH, the total number of "Report of Head Injury During Sports Season Forms" that they receive and the total number of students who sustain head injuries and suspected concussions when engaged in any extracurricular athletic activities. It was further noted that coaches, trainers and volunteers teach form, techniques and skills that minimize the risk of sports-related head injuries and are prohibited from teaching techniques that would endanger health or the well-being of students, such as using their helmets as a weapon. Dr. Smith stated that they are asking school nurses to review Pre-Participation forms that indicate a head injury and to be part of the team that provides

educational materials to teachers, staff, and students and to participate in the graduate re-entry plan for students with a concussion returning to school, to help monitor the student during the day and change their level of activity or send the student home if needed, and to collaborate with teachers on this.

Staff noted that public hearings will be held in March of 2011 and then staff will return to the Council with a summary of the results of the public hearing/public comment period in late spring and seek approval of the proposed regulations. Dr. Smith said implementation of the regulations is ongoing, since they are meant to be in effect now, but full implementation is expected for the next school year of 2011.

Ms. Carlene Pavlos, Director, Division of Violence and Injury Prevention noted that her division has responsibility for looking at all unintentional injuries and has been working with CDC on the "Heads Up Concussion" training materials and working on this issue with the Brain Injury Association of Massachusetts as part of the Traumatic Brain Injury Prevention since 2007.

Discussion followed by the Council. Please see the verbatim transcript for Dr. Smith's full presentation and Council discussion on this matter. Dr. Muriel Gillick made a recommendation that staff provide feedback on this regulation to the Legislature and encourage a broadening of the population covered to include college students, town sports teams like Pop Warner and Little League. Dr. Woodward made suggestions (1) Perhaps the Department could create a software program that each school could use to record the data for the Department instead of each having to develop their own software data-base; (2) DPH develop a training DVD that schools could show to the entire teacher/student body each season and (3) for health care providers do a joint symposium with the Mass. Medical Society on concussions and (4) perhaps a webinar for training.

Discussion continued and Council Member Josè Rafael Rivera recommended that the word "guardian" be in the regulations as well as "parents". Staff said it was in the current language. Mr. Rivera

also suggested that foster parents receive the training. Staff agreed that was a good idea and would explore the idea with DCF. Mr. Lanzikos encouraged a public information campaign around success stories and added that the parent training should be continually updated because if a parent has to take the same training year after year that would defeat the purpose. Staff replied that they are working the CDC on trainings and hope to make continuous advancements in the trainings. It was noted that cheerleaders are included in the regulations.

NO VOTE/INFORMATION ONLY

PROPOSED REGULATIONS: INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 532.000, TO ADD SECTION 532.300: REQUIREMENTS FOR USE OF MOBILE POULTRY PROCESSING UNIT:

Ms. Suzanne Condon, Director, Bureau of Environmental Health, presented the proposed amendments to Mobile Poultry Processing Units (MPPU). She was accompanied by Kim Foley, Acting Director, Food Protection Program, and Attorney Lisa Snelling sitting in for Attorney Priscilla Fox, both of the General Counsel's Office. Ms. Condon said in part, "…What is a Mobile Poultry Processing Unit? It brings the slaughter house to the farm…There has been an increasing desire on the part of the consumer to buy local and close to home and not worry about massive slaughter house type situations…Most of the units are on trailers and they literally bring the slaughter house to the farm. There are several advantages of MPPUs. It is less stress for the birds and reduces the biosecurity risk and you don't have to worry about birds being diseased going from one place to another. It allows greater producer control of the process from start to finish. The same people are involved at the beginning and at the end. It is potentially more cost effective….This is an economic revenue enhancer for small farmers across the State of Massachusetts and for producers to be above the radar. Historically, you could have chickens in your own backyard and do poultry processing for your own consumption but the desire to go beyond that has been enhancing over the years."

Ms. Condon continued, "…Who is involved in this? There are actually lots of players involved. At the Federal level, it's the United States Department of Agriculture (USDA) and their Food Safety Inspection Service. At the State level, it is DPH working with our partners at the Department of Agricultural Resources and the Department of Environmental Protection, and at the local level, it is both Boards of Health and Town Planning and Zoning Boards because of the noise and trade issues. There are a series of regulatory concerns that cause these players to be involved such as flock health, biosecurity, environmental impacts to water, chemicals that are used, viscera, bacteria, nuisances, food safety, food-borne illness, sanitation issues and adequate supply of potable water."

Ms. Condon informed the Council that several farmers approached them a couple of years ago wanting to use MPPUs, though our regulations did not allow it. They suggested a pilot program. Working with sister state agencies and the DPH Legal Office they decided to do a pilot with six farms in Massachusetts working with the New England Small Farm Institute to develop guidance and protocols for how this could be done safely in Massachusetts from 2008 to 2010. Funding was available from the Federal USDA Rural Development Funding, the Mass Society for Promoting Agriculture, the Mass DAR's Agriculture Innovation Center and Northeast Sustainable Agriculture Research and Education.

"There were six farms on Martha's Vineyard that participated with the IGI pilot program", continued Ms. Condon, "Kim and our Food Protection Program inspectors visited the farms several times throughout the season and local health agents on the Island also assisted with inspections on the processing dates when DPH staff couldn't be there." Ms. Condon noted training sessions on operating and using MPPUs safely is required.

Staff's memorandum to the Council, dated January 12, 2011, describes the proposed changes to the Department's food regulations (105 CMR 532.000): (1) Poultry producers and sellers shall comply with federal law in all operations they conduct under the federal

exemptions under the Poultry Processing Inspection Act (PPIA), (2) the amendments clarify the licensing requirements of M.G.L. c.94, § 120, which requires all persons who slaughter or process poultry to obtain a license from the Department, (3) the amendments request deletion of sections 532.202 through 532.209 and 532.400, because they are obsolete. The amendments will add section 532.300, which will refer to protocols under development that will contain detailed requirements for the use of MPPUs. Current requirements will be codified by cross reference to federal law.

Staff expects the amendments to go into effect on May 1, 2011. This will allow time for the public hearing/public comment period, and to make any needed revisions to the regulations, time to come back to the Council for final promulgation in April and time to publish the final regulations in the Massachusetts Register. Staff's memorandum stated, "It will provide a framework for farmers to make business plans for their 2011 poultry season and to attend required training sessions on operating and using MPPUs safely."

Discussion followed by the Council, please see the verbatim transcript for the full staff presentation and Council discussion. Responding to questions by Council Member Dr. Michéle David, Dr. Kim Foley, Acting Director, Food Protection Program, DPH noted that inspections of MPPUs will be done every 12, 24 and 48 months. Dr. Foley further noted that federal law requires every bird to be inspected but the federal exemption actually exempts MPPUs from continuous inspection, this bird-by-bird inspection. However, DPH will do regular inspections. Dr. Alan Woodward, Council Member, and also, Chair of the Board of Health in Concord, suggested that it may be easier and less expensive to grant the slaughtering license to the MPPUs instead of the farmer, if the units are going to go to a lot of farms. DPH staff responded that they did license the processing group in Martha's Vineyard instead of each farmer during the pilot and that it depends on the processing model used, some MPPUs have the farmer do the slaughter and others bring a slaughtering crew with the unit. Ms. Condon said in part, "We anticipated that there may be modifications needed over time…that is the idea behind companion protocols so minor modifications can be made without coming back to the PHC."

NO VOTE/INFORMATION ONLY

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 300.000: UPDATES TO REQUIREMENTS FOR USE OF ELECTRONIC SYSTEM FOR DISEASE REPORTING:

Mr. Kevin Cranston, MDiv, Director, Bureau of Infectious Disease accompanied by Alfred DeMaria, Jr., MD, Medical Director and State Epidemiologist, and Gillian A. Haney, MPH, Director, Integrated Surveillance and Informatics Services (ISIS) addressed the Council regarding the use of an electronic system for disease reporting. Mr. Cranston made introductory remarks and said in part, "…In an era where electronic laboratory reporting, electronic medical records, health information exchanges are increasing the standard and the norm for the collection, management and reporting of medical information, we are presenting regulations that would expand the use of our currently-in-place electronic surveillance system known as MAVEN, and Gillian will be discussing that in detail, that has been in operation since 2006, and currently is utilized by over 50% of local boards of health. Our goal in this presentation is to introduce you to the system, to give you some very specific information about its architecture and its functionality…"

Ms. Haney addressed the Council and stated in part, "…MAVEN stands for the Massachusetts Virtual Epidemiologic Network. It is an integrated web-based disease surveillance and case management system that we use for infectious disease follow-up. It also has outbreak response capacity. We currently have an interface with our electronic laboratory reporting system as well as a medical record reporting infrastructure so data are able to flow directly into MAVEN...that allow local health and the epidemiologists, the nurses at the state level to initiate investigations in a timely and cooperative manner. It allows us to streamline the business processes and eliminate paper…"

Ms. Haney noted that the security features of MAVEN uses the same encryption technologies as the banking industry, a secure socket

layer; and that DPH staff only have access to diseases under their purview. Local health departments and boards of health only have access to information in their own jurisdiction, only for their town or city. However, there is case-sharing capability between towns/cities so that local entities can do their disease follow-up on a case and share information. The system is hosted within the Executive Office of Health and Human Services (EOHHS) Virtual Gateway with its own security and firewall protection. She noted that data received from a variety of local public health partners is de-identified and sent on to the federal Centers for Disease Control (CDC).

Ms. Haney compared the prior paper-based system with the electronic MAVEN system in place. Previously it would take about six months to complete a disease investigation; now an investigation can be done in three weeks, allowing both the state and local health departments to initiate their case investigation promptly. She said in part, "…The MAVEN Disease Surveillance and Case Management System is an integrated data repository that allows us to filter reports and allows real time information sharing and to establish data standards, quality control assurance, case investigation and case management cluster identification and outbreak response and extract information from the system to do prompt analysis. It also means the state and local health departments are working off the same information…." Ms. Haney said the system was critical during the H1N1 outbreak, allowing them to quickly identify high risk populations who were very susceptible to disease.

She said further, "…Now we have an electronic laboratory report that gets automatically sent into the system through the ELR infrastructure. The system may then actually automatically recognize what lab data are coming in, create a disease event, page the Local Board of Health, as well as notify the epidemiologist of the day, so that the two entities can coordinate the investigation, and it enables real time electronic information. The local board of health department is taking the lead on the investigation. The epidemiologists know what is going on, as well, and can step in and assist as necessary. Timeframe to completion, three weeks, assuming there are no outbreaks and everything goes well…"

Ms. Haney noted the disease modules that are in the system: epidemiology and immunization disease modules (live in September 2006) including enteric diseases, vaccine preventable diseases, tick borne, hepatitis, Zoonotic diseases and MBT events. Tuberculosis (TB) case management went live in 2007 and the refugee immigrant health program for case management and surveillance went live in October 2010.

Dr. Alfred DeMaria, Medical Director, Bureau of Infectious Disease gave a demonstration of MAVEN's functionality using maternal Hepatitis B. In this regard, he said, "If we can do the appropriate things at birth, we can prevent a 90% chance of lifetime infection with Hepatitis B, and the high risk of dying of liver failure and hepatic cancer in these children." MAVEN allows them to identify the Hepatitis B surface antigen infected women who are pregnant and make sure the babies get the appropriate prophylactic treatment. This allowed DPH to give vaccine to the contacts of these women as well. Regarding Hepatitis C he stated, "Turnaround time on Hepatitis C cases has been enormous. Prior to MAVEN, it would literally take up to a year to elucidate these cases and now it is down to a matter of weeks and this has been extremely helpful identifying acute Hepatitis C cases or recent Hepatitis C cases in adolescents and young adults, which we have seen as an increasing problem in Massachusetts." MAVEN is also used for Lyme disease reporting and Influenza reporting.

In closing, Dr. DeMaria said, "MAVEN shares the same platform with our Prescription Monitoring Program and with the Immunization Registry that is being piloted in the near future and so for clinicians and for local public health, it would be sort of a seamless system and have one Virtual Gateway Entry for those who have appropriate and approved access to these systems. Ultimately, the goal is to have the providers reporting to this system as well…"

Mr. Cranston explained the proposed revisions to regulations 105 CMR 300.000. He noted, "Our proposed revisions are a collection of regulations governing reportable diseases and surveillance, as well as

isolation quarantine requirements that define the coordinated powers and responsibilities of the Department of Public Health and Local Boards of Health with regard to reportable conditions. There are two sections 105 CMR 300.110 and 105 CMR 300.160 that have the identical language change in both. The current language allows the Department to stipulate the manner in which disease reporting will occur…The new language would specify and clarify a secure electronic disease surveillance and case management system designated and defined by the Department, otherwise known as MAVEN." The changes outlined by Mr. Cranston include:

- The existing language 'The report shall be in a form or manner deemed acceptable by the Department.' The new proposed language is 'Each local board of health shall utilize the secure electronic disease surveillance and case management system designated and maintained by the Department.'
- New language is proposed under a Definition for 105 CMR 300.020: Disease Surveillance and Case Management System is defined as: 'A secure electronic system utilized by the Department and local boards of health to monitor or respond to diseases dangerous to the public health. The system shall be designated and maintained by the Department.'

Mr. Cranston further noted that his Bureau will be receiving federal funds from the CDC Infrastructure Grant allowing them to expand staff to do project management and training work with local board of health staff. In addition, they will expand the Help Desk support for the end users. The Virtual Gateway is the portal to the MAVEN system therefore the Virtual Gateway staff will need additional staff. He said, "We have committed in the grant a goal of having 95% of local boards of health live on MAVEN by the end of December 2012."

Public hearings are planned in Eastern and Western Massachusetts to elicit comments from local boards of health and the community on the proposed regulations. Following the public hearings/public comment period, the proposed regulations will return to the Public Health Council for approval in May or June 2011. Mr. Cranston said they will return to the Council with a one-year report on the status of MAVEN in June of 2012.

Discussion followed by the Council. Please see the verbatim transcript for staff's full presentation and the full Council discussion. Discussion was held about the security of the system and why some local boards of health may be reluctant to join the system. Ms. Haney replied to the security questions extensively and Mr. Cranston responded to the local boards of health question by stating, "… being accustomed to paper-based systems or Legacy electronic systems and that a change to a web-based system means learning a whole new set of skills that may be daunting to some at first…" He noted staff's commitment to helping local boards of health feel comfortable utilizing the system. A question by Mr. Lanzikos was raised about practicing Infectious Disease Specialists and academic researchers accessing the system. Ms. Haney replied that at this time there are no immediate plans to have individuals access the system, maybe long term down the road at some point. As far as practitioners accessing the system, a pilot was done with an Infection Control Practitioner entering the information and reporting cases directly into the system and staff is interested in exploring that in the next several years. It was noted that DPH developed MAVEN in partnership with the software company and is leading the way as a model for other states. MAVEN has since been adopted by ten to twelve other cities, states or jurisdictions including New York City, North Carolina, North and South Dakota, Minnesota, Houston and Washington DC.

Council Member Dean Harold Cox asked the final question, "In our role as regulators, it is important for us to be careful about how many regulations we put in place and to be very thoughtful about why we are putting them in place and why you do this….Why is it necessary to actually have a piece of regulation that says people will use this, as opposed to just getting people to just join the system? I am thinking about how many regulations we put in place and whether you need a regulation in order to move us to the next place?" Mr. Cranston responded, "We currently have the regulatory authority to designate the manner in which disease reporting is received. This is essentially a clarification of that existing authority and to specify a secure electronic means. This is not a significant regulatory change, although it does signal very loudly that we want

to work with a single state-of-the-art, 21st century system and we wanted that to be clear…" Mr. Cranston noted further that they do have substantial local board of health support from users who have gained efficiency with the system, and that DPH has committed in the grant to achieve 95% LBOH coverage by 2012; and that it is intended to accelerate the adoption of a superb system.

Chair Auerbach added, "One of the challenges that we have in Massachusetts in particular is the fact that we do not have regional or county health and so the number of entities that DPH is dealing with, in terms of reporting, is greater than any other state in the country. We have 351 communities and some have only a few hundred people in it and limited capacity. I think that is part of the reason that sometimes we need to move to the regulatory arena, to get to the point where we can have some level of consistency and it is unlikely the smaller communities with only a few cases would voluntarily participate. I think that is part of the dynamics we face in this state…"

NO VOTE/INFORMATION ONLY

COMPLIANCE MEMORANDUM: PREVIOUSLY APPROVED PROJECT APPLICATION NO. 3-3B62 OF LOWELL GENERAL HOSPITAL- Request for a significant change to decrease the project's maximum capital expenditure and gross square footage and to build out approved shell space:

Ms. Joan Gorga, Director, Determination of Need Program, presented the request for a significant change to Previously Approved Project Application No. 3-3B62 of Lowell General Hospital, Lowell. Chair Auerbach noted that this project was unusual in that the request is to scale back the size of a previously approved DoN in terms of both square footage and dollars.

Ms. Gorga noted, "Lowell General Hospital is before you for a significant change to its capital construction project approved in March 2009. The hospital is requesting a 23% decrease in the Maximum Capital Expenditure (MCE) for the construction of a six-

story bed tower on the main campus in Lowell. The decrease is about $27.6 million dollars. The decrease was achieved by a combination of advantageous timing and reductions in square footage. Due to the effects of the economic recession on both the construction industry and the financial markets, Lowell General found that this was a favorable time to build and to finance the project. In addition, the hospital has reduced square footage of the project to achieve greater space efficiencies, has eliminated the rooftop penthouse, which contained mechanical equipment, and has scaled down the finishes and design of the building."

Ms. Gorga continued, "The community initiatives originally offered by the applicant included a provision for a proportional reduction in the event of a reduction of the project's MCE and the hospital has discussed this revised funding with the Office of Healthy Communities. The contribution level will be maintained at 5% of the lowered MCE, and the revised funding will require Lowell General to provide a total of $4,854,556 dollars over 14 years at $346,754 per year. The allocations to specific programs may be redistributed because of potential changes in community needs, subject to approval of the Office of Healthy Communities and the Executive Committee of the Greater Lowell Health Alliance. Staff recommends approval with conditions of the request from Lowell General Hospital to decrease the MCE to $97,091,054 (October 2010 dollars) and decrease the gross square footage to 192,195 gsf and to approve the build-out of 23,881 gsf of previous approved shell space."

Chair Auerbach asked the applicant if there would be any changes to the service mix. The applicant came to the table, Mr. Win Brown, Vice President for Administration, Lowell General Hospital: "…The mix of services is the same. When we did our value management and value engineering of the project, we slimmed down the footprint slightly and that really came through the whole building on every floor…" He indicated that the project will have the same number of beds as originally proposed and that they will be adding the Labor and Delivery Unit because they can afford to do it now.

Chair Auerbach stated, "This will set a standard by which we may look at other DoN applications since in fact we now know applications can be done, achieve the same outcomes with lower cost and lower square footage." Mr. Brown replied, "We are at a unique point in time. The financial market and the construction market have all changed dramatically since 2009, and we had to wait a little bit of time before we were going to be able to do the project and so that is really what has afforded us the opportunity to do it the way we are doing it."

Discussion continued by the Council, please see verbatim transcript for full discussion. In response to Council questions, Mr. Brown noted that cost savings are a result of putting the mechanicals on the roof in a self-enclosed mechanical structure instead of building a top floor and that the overall footprint of the building is slightly smaller with a little less circulation space and lastly, the level of finish detail in some areas is lower than originally planned. Chair Auerbach asked Ms. Gorga if she was finding other projects coming in remarking about decreased cost in terms of major construction projects. Ms. Gorga said in part, "We are finding, in the long term care industry, that projects that had been approved a number of years ago for replacement are not replacing. They are coming in as a significant amendment to renovate rather than replace."

One of the members asked about their being green plans for this project, Mr. Brown replied, "We have not moved forward to LEED Certification on this project, but the state has come forward with standards that they would like us to have as far as being green and energy efficient, and using materials that are efficient, as well, and we are doing all of those things. This mechanical penthouse, in particular that we are putting on is a very efficient system for the hospital, and we are paying a premium for it, actually, to do it, and, at the same time, we are also upgrading our central plant and so we are going to have a very efficient energy footprint when we move forward."

Dr. Alan Woodward made a motion to approve staff recommendation of approval of the project. After consideration, upon motion made

and duly seconded, it was voted unanimously to approve with conditions **Previously Approved Project Application No. 3-3B62 of Lowell General Hospital, Lowell** for a significant change to decrease the project's maximum capital expenditure and gross square footage and to build out approved shell space. This approved significant change provides for approved GSF of 192,195 GSF (184,297 GSF for new construction and 7,898 for renovation) and shell space to be built out of 23,881 GSF. The holder shall provide a total of $4,854,556 over 14 years at $346,754 per year. Please see staff's memorandum to the Council dated January 12, 2011 for the conditions attached to this approval which is attached along with the transcript of these proceedings as **Exhibit No. 14,968.**

CATEGORY 1 APPLICATION: PROJECT APPLICATION NO. 4-3B94 OF WHITTIER REHABILITATION HOSPITAL: Request for transfer of ownership of Metro West Rehabilitation Corporation d/b/a Whittier Rehabilitation Hospital, Westborough, an acute inpatient rehabilitation hospital to Whittier Healthcare Holdings II, Inc.

Note for the record: Attorney Donna Levin, General Counsel, left the room at this point due to a conflict of interest on this application and Attorney Susan Stein, First Deputy General Counsel, acted as General Counsel for this docket item.

Mr. Jere Page, Senior Program Analyst, Determination of Need Program, presented the Whittier Rehabilitation Hospital application. He said in part, "…The application before the Council today is from an original license involved with a transfer of ownership of Metro West Rehab Corporation doing business as Whittier Rehabilitation Hospital in Westborough. The Hospital is an 88-bed acute inpatient rehabilitation hospital located at 150 Flanders Road in Westborough. Dr. Alfred L. Arcidi, the sole shareholder of Metro West Rehabilitation Hospital, d/b/a the Whittier Rehabilitation Hospital in Westborough, intends to transfer a 100% of his shares in Metro West Rehab Corporation to Whittier Healthcare Holdings II, Incorporated. This is being done in order to ensure a smooth generational transition to Dr. Arcidi's sons, Alfred J. Arcidi, Philip M. Arcidi, and Michael P. Arcidi,

who are the shareholders of Whittier Healthcare, and who will continue to manage the hospital after the transfer is completed."

Mr. Page indicated that this application could not use DoN's abbreviated transfer of ownership process because Dr. Arcidi's sons do not live in the hospital's service area which is a required standard under that procedure. They had to file a regular DoN application and DoN reviewed all the DoN factors instead of just the four standards under the Alternative Transfer of Ownership procedure. The application satisfies all nine of the review factors and staff recommended approval with one condition. The condition is that the applicant agrees to comply with any pending recommendations by the Department's Office of Health Equity regarding enhancement of its existing Interpreter Services at the Westborough facility. Alfred J. Arcidi was in attendance to answer any questions of the Council but he did not address the Council. The Council had no questions.

Mr. Albert Sherman moved approval of the application. After consideration, upon motion made and duly seconded, it was voted unanimously to approve Project Application No.4-3B94 of Whittier Rehabilitation Hospital, Westborough based on staff recommendation. The staff summary dated January 12, 2010 is attached and made a part of this record as **Exhibit No. 14,969**. As approved, the application provides for the transfer of ownership of Metro West Rehabilitation Corporation d/b/a as Whittier Rehabilitation Hospital to Whittier Healthcare Holdings II, Incorporated, as noted above and in the project's staff summary. There are no capital expenditures or incremental operating costs associated with this project.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF NOVEMBER 10, 2010:

Dr. Albert Sherman moved approval of the minutes of November 10, 2010. After consideration, upon motion made and duly seconded, it was voted unanimously (Dr. David abstained) to approve the minutes of November 10, 2010 as presented. Dr. Woodward commented that he thought the minutes were good. Dr. Woodward also inquired

about the follow-up items listed in the minutes that they have not gotten feedback on yet – the issue of supervising physicians of nurse anesthetists and the others on the follow-up list. The Secretary of the Public Health Council agreed to forward the follow-up list of the minutes to the appropriate program directors for follow-up.

SEMI-ANNUAL REPORT ON ADJUDICATORY DECISIONS:

Chair Auerbach asked the Council if they received the recent semi-annual report on adjudicatory decisions, prepared by Attorney James Ballin, Deputy General Counsel. He asked further if the Council was content with him reviewing these actions on their behalf, saving the Council's time. The Council Members expressed agreement. The Commissioner said, "Unless we hear otherwise, we will assume this is your wish."

FOLLOW-UP ACTION STEPS:

- Staff encourage the Legislature to broaden the head injury and Concussions in Extracurricular Athletics Regulations to include college students and town sports teams (Gillick to Smith/Pavlos)
- DPH create a software program for all cities/towns to use to record the DPH required data reporting (Woodward to Smith)
- DPH create a training DVD for all schools to use each season to show students/teachers for head injury and concussions training (Woodward to Smith)
- DPH and the Mass. Medical Society hold jointly a symposium for health care providers, on concussions (Woodward to Smith)
- Use a webinar for training on head injury and Concussions in Extracurricular Athletics (Woodward to Smith)
- Have Foster Parents receive head injury and concussions in extracurricular athletics training. Explore idea with DCF. (Rivera to Pavlos)
- Public Information Campaign around success stories on head injury and concussions in extracurricular athletics (Lanzikos to Smith)

- Parent training should be continually updated so parents don't have to sit through the same exact training each year (Lanzikos to Pavlos/Smith)

LIST OF DOCUMENTS PRESENTED TO THE PHC FOR THIS MEETING:

- Docket of the meeting
- Copy of the meeting notices to A&F and Secretary of the Commonwealth
- Draft minutes of the Public Health Council for the Meeting of November 10, 2010
- Informational briefing memorandum and proposed new draft Regulations on 105 CMR 201.000: Head Injuries and Concussions in Extracurricular Athletics
- Informational briefing memorandum and proposed draft Amendments to 105 CMR 532.000, 532.300: Requirements for Use of Mobile Poultry Processing Unit
- Informational briefing memorandum and proposed Amendments to 105 CMR 300.000: Updates to Requirements for Use of Electronic System for Disease Reporting
- Determination of Need (DoN) compliance memorandum to the Council on Previously Approved Project No. 3-3B62 of Lowell General Hospital
- DoN staff summary to the Council on Project Application No. 4-3B94 of Whittier Rehabilitation Hospital

The meeting adjourned at 11:25 a.m.

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Chair John Auerbach

LMH